FIRST STEPS FINANCIAL INFORMATION FORM

Check one: ☐ Initial ☐ Update

Child's Name:_____

CBIS No._____ **SSN:**_____

INCOME INFORMATION:

Most recent gross family income:_____

Number in Household:_____ **Family Share Category:**_____

Family applied for exemption from Family Share: ☐ **Yes** ☐ **No**

If yes, check reason: ☐ **Temporary Suspension/Waiver** ☐ **Inability to Pay**

Family was approved for exemption: ☐ **Yes** ☐ **No** ☐ **Pending**

KCHIP/MEDICAID INFORMATION:

Family's income is at or below 200% of poverty level: ☐ **Yes** ☐ **No**

Child already has a medical card: ☐ **Yes** ☐ **No**

If yes, please write 10-digit number:_____

Family needs to be contacted about completing KCHIP/Medicaid application.

☐ **Yes** ☐ **No**

Family went to their local Department for Community Based Services (DCBS) office (or sent representative) and completed KCHIP/Medicaid application.

☐ **Yes** ☐ **No**

Application Submission Date:_____

Application was approved for ☐ **KCHIP** ☐ **Medicaid (includes HCBS waiver).**

Application was denied for ☐ **KCHIP** ☐ **Medicaid (includes HCBS waiver).**

Reason(s) given for denial:_____

_____

☐ **Application is still pending.**

☐ **Family refused to apply. Reason:**_____

_____

(Note: Families with incomes in category one must apply for KCHIP/Medicaid. Families refusing to apply (except for religious reasons) will be assessed $50/month Family Share. Check category 5 on the appropriate summary sheet (either Demographic Changes/POE Home Visit Form or IFSP Meeting Form).

Please obtain release of information before sharing financial information with provider(s).
Please do not share income information with provider(s).

Child's Name:_____

CBIS No._____ **SSN:**_____

INSURANCE COVERAGE:

(Note: Families who are covered by private insurance and Medicaid need to be reminded that they signed a "Third Party Liability" form during the Medicaid application process, agreeing to have their insurance billed first for all services that may be covered by Medicaid. This was a condition of accepting the medical card. State regulation references: 911 2:200E; 907 KAR 1:001 & 1:005. State statute references: KRS 205.520 & 520.624. The Commission will bill private insurance for dually covered children.)

Child is currently covered by insurance. ☐ **Yes** ☐ **No**

Insurance Company's Name _____

Address_____

Phone No. (_____)_____ **Policy No.**_____

Insurance Effective Date:_____ **Child's Date of Birth:**_____

Patient ID No._____ **Group No.**_____

Policyholder's Name:_____

Policyholder's Relationship to Insured:_____

Policyholder's SSN:_____ **Date of Birth:**_____

Policyholder's Employer:_____

Minimum annual dollar amount that the insurance company would have to pay in order for Family Share fee to be waived: _____

Family has chosen providers who can bill insurance. ☐ **Yes** ☐ **No**

☐ **Some providers can bill family's insurance; others cannot.**

☐ **N/A – child has Medicaid and private insurance. CCSHCN will bill insurance.**

Comments:_____

_____

Completed by:_____

Name Printed. Please denote ISC or PSC.

_____ _____

Signature **Date**

SC's Phone Number: (_____)_____

Keep this form in child's file. Do not send to CCSHCN (unless requested) or CBIS.

Please obtain release of information before sharing financial information with provider(s).
Please do not share income information with provider(s).